

## SURGERY

UNDER THE CHARGE OF

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**Transplantation of Fascia for Pointed-toe Deformity.**—ORTH (*Zentralbl. f. Chir.*, 1916, xliii, 812) says that pointed-toe deformity has increased of late in military and non-military service. In many cases gymnastic and other corrective exercises were unsuccessful, and only operation gave hope of making the patients useful. So long as the tendons are not too much contracted or degenerated by cicatricial tissue, the methods of Beyer and Vulpis are sufficient. But when these conditions do exist or the original lesion affects the tendon itself, we may lengthen the tendon by the transplantation of a suitable piece of fascia to fill the gap resulting from the division of the tendon. The transplanted piece of fascia did not become necrotic or contract. Passive movements were begun after fourteen days and active movements after three to four weeks. The results were good in three soldiers so operated on. Two of them returned to service in the field and one to garrison duty.

**Proving the Collateral Circulation in a Case of Femoral Aneurysm by the Henle-Coenen Sign.**—DREYER (*Zentralbl. f. Chir.*, 1916, xliii, 825) proceeded as follows in a case of aneurysm in Hunter's canal: He exposed the femoral vessels central to the aneurysm in an easily accessible place and clamped the artery here. He then isolated the vessels in the popliteal space, and divided a lateral branch of the popliteal artery. The free bleeding from the central end of the divided branch proved a sufficient collateral circulation to justify the application of a simple ligature to the femoral artery on the central side and another to the popliteal artery on the peripheral side of the aneurysm. There was not the slightest disturbance in nutrition. The patient got out of bed on the eighth day and walked around. The author offers the following modification of the proof of the condition of the collateral circulation: The application of a preliminary clamp on the peripheral as well as on the central side of the aneurysm.

**The Electromagnet in War Surgery.**—CORDS (*Zentralbl. f. Chir.*, 1916, xliii, 865) refers to Capelle's article on the treatment of erysipelas with artificial sunlight and relates his own experience with the method. He begins with daily ten-minute exposures and obtains favorable results. Recently he began to use exposures to the rays of the sun. According to his small experience, the exposure to the free air and sun is to be preferred to the exposure to artificial sunlight. One patient with recurring erysipelas and a perforating, sequestrating, gunshot

wound of the thigh, had become exhausted from several attacks of erysipelas and long-continued fever. In the midst of the fever, he was left continuously on a veranda, with the naked limb exposed to the air and sun. In two days the temperature had fallen to normal and the erysipelas had disappeared. He recovered rapidly but after a longer interval than usual had a recurrence of the erysipelas. This attack, however, was of much shorter duration than the preceding ones, which were much more severe.

**The Effect of the Pointed Bullet on the Shaft and Ends of the Bone.**

—MACKOWSKI (*Deutsch. Ztschr. f. Chir.*, 1916, cxxxvii, 403) says that extensive splintering was found most frequently in the shaft and usually in what is termed the butterfly figure. This resulted when the bullet struck about midway in the width and length of the bone. When it struck the shaft in the middle of its width and near the epiphyseal end, the fragments lying toward the middle of the shaft were longer than toward the epiphyseal end, which often broke off transversely. When the bullet so hit the shaft as to divide it into two unequal parts, the larger fragment broke into large fragments and the smaller into smaller fragments. The stronger and thicker the shaft, the larger were the fragments. In fractures of the shaft of the femur the fragments were larger than in fractures of the shafts of the smaller bones, as the forearm and leg. Fractures of the shaft without division of continuity occurred almost always in the slender forearm and leg bones. They were not observed in the humerus or femur. The most frequent fracture of the femoral shaft is the large splintered oblique fracture with long pointed fracture ends. Transverse fractures were seen almost only in the shaft of the humerus. The humeral head was usually bored through without splintering, although in some cases small splinters occurred.

**Gunshot Wounds of Peripheral Nerves.**—STOOKLY (*Surg., Gynec. and Obst.*, 1916, xxiii, 639) based his paper on a study of 75 cases of nerve injuries, observed in the present war in the British Military Service. He says that peripheral nerves may be injured by projectiles, pieces of bone or foreign bodies, and may be implicated secondarily by scar tissue, or callus, or both. Diagnosis cannot be made before operation between anatomical and physiological division. Diagnosis can usually be made in cases with incomplete division. In war surgery primary suture is rarely possible due to infection. Operation is indicated when complete division is diagnosed. Nerve freeing is in many cases to be preferred to excision and suture. When the nerve is widely implicated and there is a large loss of continuity, it is better to do nerve transference or nerve transplantation than tubulization or suture with the nerve under tension. Stretching of the nerve should not be done as it causes karyolysis of the nerve cells in the anterior horn with subsequent degeneration of the nerve axon in the proximal nerve trunk. Efficient splinting to prevent contractures and over-stretching of the muscles is imperative, both before and after operation. The musculospiral nerve injured in its lower third does show loss of sensation on a narrow band over dorsum of thumb, usually only loss to cotton-wool and temperature sense. Injury to the musculospiral